HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Neuromyelitis Optica Spectrum Disorder (NMOSD)

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Enspryng ® (satralizumab), ☐ Ruxience ® (rituximab-pvvr), ☐ Soliris® (eculizumb), ☐ Uplizna™ (inebilizumab-cdon)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a specialist in the treatment of neuromyelitis optica spectrum disorder (NMOSD)?	☐	☐	
2. Does the member have a confirmed diagnosis of NMOSD with positive AQP-4 antibodies and at least one core clinical characteristic such as: optic neuritis, acute myelitis, area postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy, acute diencephalic clinical syndrome, or symptomatic cerebral syndrome with brain lesions?	☐	☐	**Please provide documentation**
3. Is an Expanded Disability Status Scare (EDSS) score equal to 8 or less?	☐	☐	**Please provide documentation**
4. Has the member had at least 1 relapse that required rescue therapy in the last 12 months or 2 or more relapses that required rescue therapy in the last 24 months?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of any of the medications listed in this policy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a clinically significant response to therapy demonstrated by one of the following: • Decrease in relapse rate	☐	☐	**Please provide documentation**

• Improvement of symptoms or stabilization of symptoms associated with relapse • Improvement in EDSS score			
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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